Application for Medicare Savings for Qualified Beneficiaries
QMB, SMB, QI-1, QI-2

Si necesita este formulario en Español, llame al 1-800-482-8988 y pida la versión en Español

If you need this material in a different format, such as large print, contact your DHS county office.

Please answer all questions as completely and accurately as possible. If you do not have enough space for your answer, attach another sheet of paper to this application.

Last Name	First Name	MI	Social Security Number

Medicare Number	Railroad Retirement Number	VA Claim Number

Birth Date	Race	Sex	County of Residence	Telephone Number

Street Address	City	State	Zip Code

Mailing Address (If Different)	City	State	Zip Code

Are you 65 years or older? ☐ Yes ☐ No

Are you: ☐ Blind ☐ Disabled

Are you (check one):
☐ Married ☐ Separated
☐ Widowed ☐ Divorced
☐ Single

Are you a U.S. Citizen? ☐ Yes ☐ No Submit documentation of alien status.

Living arrangement: (check one) ☐ Own Home ☐ Renting ☐ Other's Home ☐ Assisted Living

Please complete the following section for your spouse, if you live in the same household.

Last Name	First Name	MI	Social Security Number*	Date of Birth

Medicare Number	Railroad Retirement Number	VA Claim Number

- The Social Security Number is required if your spouse is applying for benefits.

Are you applying for your spouse also? ☐ Yes ☐ No If yes, complete the following.

Is your spouse a U.S. Citizen? ☐ Yes ☐ No Submit documentation of alien status.

Is your spouse 65 years or older? ☐ Yes ☐ No

Is your spouse: ☐ Blind ☐ Disabled

FOR OFFICE USE ONLY

Register #		**Application Date**	**County**	**Category**	**Worker #**	**Key Date**	**OP. Initials**
Mr.							
Mrs.							
Worker #		**Denial Date**	**Reason**	**Category**	**Client Notice**	**Key Date**	**OP. Initials**
Mr.							

Mrs.							

Do you have children under 18 (or under 21 if attending school) living in the home? ☐ Yes ☐ No

If yes, please complete the following information on each child.

Child's Last Name	Child's First Name	MI	Date of Birth	Child's Income (Amount & Type)

INCOME: Do you or your spouse have income from the following?

Source of Income	Y	N	Source	Gross Pay (before deductions)	How often?	Who receives?
Retirement, Social Security, SSI, Veterans Benefits						
Employment, work, job, farming, self-employment (List all jobs for each person listed)						
Child support, alimony, unemployment benefits, worker's compensation, student loans, grants						
Miscellaneous income (part time work, babysitting, rental property, contributions from friends/relatives, roomers or boarders, insurance etc.)						

Is food, clothing, or shelter paid for or provided free of charge for you by someone else? ☐ Yes ☐ No

REAL/PERSONAL PROPERTY:

Do you own any real estate other than your home, including property that you own with others? ☐ Yes ☐ No

If yes, complete the following for each piece of real estate. **Do not list the house in which you live.** Attach additional pages if necessary.

Address or Location	Value	Amount Owed

Do you or your spouse own a car, truck, motorcycle, boat, trailer, or other vehicle? ☐ Yes ☐ No

If yes, complete the following information about each vehicle (attach additional pages as needed)

Make	Model	Year	Value	Amount Owed	Owner(s)

ASSETS: Check all assets owned by you or your spouse. Include any accounts or properties on which your name(s) appear. Include verification of trust funds. Attach additional pages if necessary.

Type of Asset	Y	N	Where held (bank, insurance co., brokerage firm, etc.)?	Account/Policy #	$ Value
Cash					
Checking Account					
Savings Account					
Certificates of Deposit					
Promissory Notes					
Stocks					
Bonds					
IRA					
Owner of a Mortgage					
Burial Plot/Crypt					
Burial Funds/Insurance					
Life Insurance					
Trusts					
Other					

HEALTH INSURANCE:

Do you have Medicare? ☐ Yes ☐ No
Does your spouse have Medicare? ☐ Yes ☐ No
Do you have other health insurance? ☐ Yes ☐ No
Does your spouse have other health insurance? ☐ Yes ☐ No

If you or your spouse have other health insurance besides Medicare, please provide the following information and attach copies (front and back) of Medicare and insurance cards.

Health Insurance Company Name	Address	Who is Insured?	Type of Coverage	Effective Date	Policy or Claim #

Would you like for someone to contact you about applying for the Supplemental Nutrition Assistance Program (Formerly Food Stamp Program)? ☐ Yes ☐ No

READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU SIGN THIS APPLICATION

- I understand that I must help establish my eligibility by providing as much of the requested information as I can.
- I authorize the Department of Human Services to make any inquiry concerning me and/or my spouse necessary to establish my eligibility for assistance.
- I understand that no person may be denied assistance on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I understand that I may request a hearing before the state agency representative if a decision is not reached on my case within the appropriate time limit or if I disagree with the decision reached.
- I agree to notify the Department of Human Services within 10 days if I or my spouse receive additional income, acquire or dispose of property or if any other changes occur in my circumstances.
- I authorize the Department of Human Services to examine all records of mine, or records of those receiving or having received Medicaid benefits through me, for the purpose of investigating whether or not any person may have committed Medicaid fraud, or for use in any legal, administrative, or judicial proceeding.
- I understand that I must provide my Social Security Number as a condition of my eligibility; and I understand that this number may be used by the Agency without my express permission in a computer match to obtain information relative to my eligibility for assistance from the Social Security Administration, Employment Security Division, Internal Revenue Service, or other agencies.
- **ASSIGNMENT OF MEDICAL SUPPORT.** I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition I automatically assign my right to any settlement, judgement, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS on my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgement, or award received by me from a third party. A third party is any person, entity, institution, organization or other source which may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent of medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

I have read the above statements, and I agree to the provisions. I understand that this form is signed subject to penalties for perjury. I understand that if I receive assistance to which I am not entitled as a result of withholding information or providing inaccurate information, such assistance will be subject to recovery by the Department of Human Services and I may be subject to prosecution for fraud and fined and/or imprisoned.

_____	_____
Signature of Applicant, Guardian, or Authorized Rep.	Signature of Applicant, Guardian, or Authorized Rep.
_____ _____	_____
Date Telephone Number	Witness (if signed by mark)/Date
_____	_____
Guardian or Authorized Rep's Address	Address of Witness/Telephone Number
_____	_____
Signature of County Office Worker/Date	Name of Person Who Helped Complete Form/Date